Major Medical – Group and Individual
(excludes Large Employer Groups)

NOTE: These standards are provided to assist the insurer in filing forms and rates. They are not intended to be all-inclusive, and are a work in progress. References beginning with "31A" refer to the insurance code as part of Utah Code Annotated (U.C.A.) and those beginning with "R590" refer to department rules as part of the Utah Administrative Code (U.A.C.). The comments are a brief synopsis of the referenced material and do not contain all requirements or exceptions. All references should be reviewed for compliance. As required by U.C.A. § 31A-21-201(2), *the insurer is responsible* for assuring that forms and rates submitted comply with Utah Insurance Code and Rules.

General Requirements		
Application	31A-21-201(3)	Questions used to elicit health condition information may not be vague and must reference a reasonable time frame in relation to the health condition.
Arbitration	R590-122 Bulletin 96-9	An arbitration provision must be properly disclosed in the policy, certificate, application and enrollment forms. It may not deprive Utah courts of jurisdiction over an action against an insurer, except as provided in permissible arbitration provisions.
Certificate Disclosure	31A-21-311	The certificate shall contain a summary of the essential features of the insurance coverage, including any rights of conversion.
Claim Settlement	31A-26-303 R590-192	Provides for fair and rapid settlement of claims and protection of claimants from unfair claims settlement practices.
Company Name	31A-21-201 & 301(1)	The exact name of the insurer and its state of domicile must appear conspicuously in the policy.
Dependent Coverage	31A-22-718	No policy that provides coverage to children may deny eligibility for coverage to a child solely because the child does not reside with the insured or solely because the child is solely dependent on a former spouse of the insured rather than on the insured. A child who does not reside with the insured may be excluded on the same basis as children who do reside with the insured.
Discretionary Authority	31A-21-201	Discretionary clauses are inequitable and misleading, violate statutory law, otherwise contrary to law, and will be prohibited from use under 31A-21-201(3)(a). Under ERISA, discretionary clauses are not allowable in an insured contract.
Endorsement or Rider	31A-21-106(2) R590-126-6.C	A contract may not be modified unless it is in writing and agreed upon. Riders or endorsements require a signed acceptance.
Examination Period	31A-22-605(10) & 606	A required time period that an insured has for policy examination.
Filing of Forms	31A-21-201 Bulletin 99-2	Forms are accepted on a file and use basis. It's the insurers responsibility that the filing is incompliance with Utah Code and Rules.
Grace Period	31A-22-607	Policies shall provide a grace period, during which the policy must continue in force.
Grievance	31A-22-629	Grievance review process.
Incontestability	31A-22-609	Only a fraudulent misstatement regarding insurability is a basis for avoidance after coverage has been in effect for two years.
Incorporation by Reference	31A-21-106 Bulletin 96-9	Except as provided in 31A-21-106(1)(b), no policy may contain any agreement or incorporate any provision not fully set forth in the policy, application, or attached documents.
Lifetime Benefit Maximums	31A-21-201	Lifetime benefit maximums may only be applied to the specific policy. A company may not impose reduce a lifetime maximum for benefits provided under any policy issued by the insurer and its affiliates
Limitation of Actions	31A-21-313 & 314	Such provisions cannot restrict the right of action against an insurer to no less than 60 days and no more than three years from the date the cause of action accrues. In addition, they may not deny Utah court jurisdictions.
Nondiscrimination Among Health Care Professionals	31A-22-618	No insurer may unfairly discriminate against any licensed class of health care providers.
Notice of Non-renewal or Premium Change	R590-126-4.C.f	A notice of non-renewal or change in premium shall be given no fewer than 30 days before the renewal date.
Notice of termination	31A-22-716	Every policy shall include a provision that obligates the policyholder to give 30 days prior written notice of termination and to notify of right to continue coverage upon termination.
Physical Exam	31A-21-201	If an insurer requires a physical exam, the insurer must pay for such exam.
Post Hospital Admission	R590-126-4.G	Policies providing convalescent or extended care benefits following hospitalization may not condition such benefits upon admission to the convalescent or extended care facility with a period of fewer than 14 days after discharge form the hospital.
Proof of Loss and Notice	31A-21-312 Bulletin 87-6	Proof of loss provision must allow the insured or claimant to file the notice and /or proof of loss as soon as reasonably possible. Failure to give any notice or file any proof of loss required by the policy within the time specified in the policy does not invalidate a claim made by the insured, if the insured shows that it was not reasonably possible to file the notice or proof of loss within the specified time and that notice was given or proof of loss was filed as soon as reasonably possible. Failure to give notice or file proof of loss does not bar recovery under the policy if the insurer fails to show it was prejudiced by the failure.
Sample Data	R590-86 Bulletin 99-2	Each form must be completed with data that is representative of the market intended to accurately reflect its purpose and use.
Terrorism, Nuclear Release & War	31A-21-201	Acts of terrorism or nuclear release or other terms of similar import may not be excluded. War; acts of war declared or undeclared; participation in a felony, riot or insurrection; or similar acts may only be excluded if the insured is an active participant..
Variability	Bulletin 99-2	All variable information must be bracketed with an explanation of the variables. Changes must be refilled prior to use.
Dependent Coverage		
Administrative or Court Ordered Coverage	31A-22-610.5	When an administrative or court order exists to allow a child enrollment privileges, coverage must be provided without regard to the enrollment season, dependency, residence or service area. Application must be accepted from the insured, the other parent, state

		agency, or child support enforcement program.
Adoption Indemnity Benefit	31A-22-610.1 R590-204	If an insured has coverage for maternity benefits, the policy must provide an adoption indemnity benefit.
Coverage from the Moment of Birth or Adoption	31A-22-610	Coverage shall be provided; for 30 days to a newborn child from the moment of birth, and to an adopted child beginning from the moment of birth if placement for adoption occurs within 30 days of the child's birth, or beginning from the date of placement if placement for adoption occurs 30 days or more after the child's birth. If payment of a premium is required to have coverage extend beyond 30 days, the policy may require notification of the birth or placement and that the premium be paid within 30 days after the date of birth or placement.
Definition	31A-22-610.5	All dependents must be covered up to age 26. The code does not provide a definition of dependent. When an insurer is creating such a definition, they must treat all dependents equally. The dependent tests for a 2 year old must be the same test for a dependent that is 25 years old. Dependent coverage may not be linked with student status.
Policy Extension for Handicapped Children	31A-22-611	Coverage of a dependent shall not terminate upon reaching a limiting age specified in the policy if the child is and continues to be both; incapable of self-sustaining employment because of mental retardation or physical disability, and chiefly dependent upon the person insured under the policy for support and maintenance.
Residence	31A-22-718	Eligibility may not be denied because the child does not reside with the insured or solely because the child is solely dependent on a former spouse of the insured rather than on the insured. A child who does not reside with the insured may be excluded on the same basis as children who do reside with the insured.
Specific Requirements		
Alcohol & Drug Treatment	31A-22-715	Each group policy shall contain an optional rider allowing for alcohol or drug dependency treatment
Conversion Rights	31A-22-703 to 712	Group conversion rights for those who have been continuously covered for at least six months immediately prior to termination
Coordination of Benefits	Rule R590-131	Requirements for coordination of benefits provisions.
Creditable Coverage	31A-30-107(5)	A carrier shall waive any time period applicable to a pre-existing condition exclusion or limitation period.
Definitions	31A-1-301 31A-30-103 R590-126 & 175	Definitions used in Utah Code and Rules. All Accident and Health forms must comply with these definitions.
Diabetes Coverage	31A-22-626 R590-200	Diabetes coverage including services, supplies, and self-management training
Emergency Services	31A-22-627	Definition of “Emergency Medical Condition” and coverage requirements.
Extension Rights (Continuation)	31A-22-714	Applicable to groups that do not have COBRA rights. Allows extension of benefits under the group policy for six months, after which conversion is available.
Inborn Metabolic Errors	31A-22-623 R590-194	Mandated coverage of inborn errors of amino acid or urea cycle metabolism
Maternity Minimum Stay	31A-22-610.2	May not be limited to less than 48 hours for normal delivery, and 96 hours for caesarean section delivery for both mother & newborn
Mastectomy Coverage	31A-22-630 31A-22-719	Mastectomy coverage must include coverage for reconstruction, prostheses, etc.; continued eligibility must not be prejudiced
Mental Health Parity	31A-22-720	Mental health limits must equal or exceed those for medical or surgical services
Non-confinement Clause	31A-2-212(6) & HIPAA	Delaying the effective date of coverage until an individual is no longer confined to a hospital or other health care institution violates provisions of the PHS Act.
Non-renewal	31A-30-107	Minimum requirements for carrier to non-renew all of its health benefit plans.
Preexisting Conditions	31A-22-107	A health benefit plan may not define a preexisting condition more restrictively than a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the earlier of the enrollment date or the effective date of coverage or for an individual insurance policy, a pregnancy existing on the effective date of coverage. A health benefit plan may not deny, exclude, or limit benefits for losses incurred more than 12 months, or 18 months in the case of a late enrollee.
Preferred Provider Provisions	31A-22-617	Non-contracted providers must be reimbursed at the rate of 75% of the average paid contracted providers.
Renewal / Termination	31A-30-107	A health benefit plan is renewable at the option of the covered insured except as listed.
Rating Requirements		
Confidentiality	31A-30-106(4)(d)	Records submitted under 31A-30-106 and its applicable section included in Rule R590-167 are considered protected records and not available to the public for inspection.
Rate Manual Filing	31A-30-106(4)(a) Rule R590-167-11.B Bulletin 99-2	A carrier shall develop a rate manual that includes a complete and detailed description of how the final premium, including fees, is calculated form the rating manual. The initial manual and any subsequent updates to the manual shall be filed 30 days prior to use. Rate manuals are accepted on a file and use basis.
Rating Methods	31A-30-104, 105 and 106 R590-167-4 and 6.	Standards for development of rating on health benefit plans offered on an individual basis or to small employers. Topics referenced are classes of business, rating bands, index rates for individual plans, standards for revising rates, rate manual changes, case characteristics, heath status adjustments, uniformity, development of reasonable rates, and record retention requirements.
Reporting Requirements		
Actuarial Certification	31A-30-103, 106, 106.5, 106.6 & 112 Rule R590-167-11.A	Due on or before **March 15**. A qualified actuary must certify to the carriers rating methods, compliance, and include all required data.

List of Policy Forms	R590-167-11.C.	Due on or before **March 15**. A carrier must submit a list of every policy form to which the rule applies, AND how to find the applicable information in the rate manual. The filing must clearly identify meeting the requirements of this section.
Statistical Report	R590-167-11.D.	A carrier must submit the statistical report, attached to the rule and available on the department web site, on or before **March 15**. The carrier must only submit the formatted report - it is not necessary to complete items (1) through (7) separately.
Mid-year Coverage Counts	R590-167-11.E.	Due on or before **August 15**, a carrier must submit is number of natural covered lives as of June 30, separately for both the small employer and individual markets.
Status of Carrier	R590-167-10.	Prior to marketing any health benefit plan to an individual or small employer, a carrier must submit a filing that indicates it wishes to be considered a covered carrier and in which markets.
Withdrawal from Market	31A-30-107(1)(f), (2) & (3) 31A-4-115 Rule R590-199	Prior to withdrawing from the Chapter 30 market, a carrier must submit a letter to the commission at least 3 working days prior to notice to the affected insureds. It must accompany a plan of withdrawal for approval by the commissioner.